

Care Central VNA & Hospice
34 Pearly Lane
Gardner, MA 01440
978-632-1230

Program Volunteer Application

Program you are interested in volunteering with: _____

Name: _____ Date: _____

Address: _____

Phone: (H) _____ (W) _____

Other: _____ Email: _____

Emergency Contact: _____

Name	Phone	Relationship
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Educational Background: <i>(use back if needed)</i>	Dates	of Completion
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Work Experience: <i>(use back if needed)</i>	Dates	of Employment
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Do you speak another language than English? No Yes

If Yes, which one(s): _____

Do you have any areas of special training, skills, talents or licensure that might be useful as you volunteer with CCVNA & H?

Where did you first hear about the CCVNA & H Volunteer Program? _____ Have you ever been a volunteer before? No Yes If Yes, please describe:

Did you participate in continuing education or training seminars during your previous volunteer assignment(s)? No Yes If Yes, please describe:

Are there areas of interest that you would like to learn more about as you volunteer with the CCVNA & H? No Yes If Yes, please comment:

Do you have reliable transportation? Yes No

Please indicate the approximate number of hours, times and days you are available to serve as a volunteer: _____

Please list three references:

Name **Address** **Phone #**

Certification and agreement: I certify that the information on this application is true, complete and correct. I authorize the Care Central VNA & Hospice to contact my references.

Applicant's Signature Date